MANAGED HEALTH CARE IIMPROVEMENT TASK FORCE
AUGUST 28, 1997 STUDY SESSION -- NOTES

Thursday, August 28, 1997 - 9:00 A.M.
Oakland Scottish Rite Center
1547 Lakeside Drive
Oakland, California

I. CALL TO ORDER [Chairman, Alain Enthoven, Ph.D.] - 9:00 A.M.

The fifth study session of the Managed Health Care Improvement Task Force [Task Force] was called to order by Chairman, Dr. Alain Enthoven, at the Oakland Scottish Rite Center in Oakland, California.

II. ROLL CALL

Task Force Secretary, Ms. Neff, took roll. The following Task Force members indicated that they were present: Dr. Bernard Alpert, Dr. Rodney Armstead, Ms. Rebecca Bowne, Dr. Donna Conom, Dr. Alain Enthoven, Ms. Barbara Decker, Ms. Jeanne Finberg, Mr. Mark Hiepler, Mr. Bill Hauck, Dr. Michael Karpf, Mr. Clark Kerr, Mr. Peter Lee, Dr. J.D. Northway, Mr. John Ramey, Ms. Ellen Severoni, Dr. Bruce Spurlock, Mr. Allan Zaremberg and Mr. Steve Zatkin.

Ex Officio members Mr. Michael Shapiro and Mr. Keith Bishop ex-officio members, were also present.

III. OPENING REMARKS - 9:15 A.M.

Chairman Enthoven announced that today's study session would focus mainly on options for organizing the government to regulate managed health care and to hear reports from several of the Expert Resource Groups. Chairman Enthoven then announced that Task Force member Ms. Kay Murrell has resigned her position with the Task Force as she has retired from her professional career and is moving out of the state.

A. Executive Director's Report [Phil Romero, Ph.D.] - 9:30 A.M.

Executive Director Romero said that Ms. Jill McLaughlin has left the Task Force staff to accept a job in the private sector and that Ms. Flo Neff has been hired to replace her as the Task Force secretary. He also introduced the new Task Force web page. The address is: http://www.chipp.cahwnet.gov/mctf/front.htm.

IV. DISCUSSION - 9:35 A.M.

A. Managed Health Care Oversight [Rescheduled from the August 7, 1997 Business Meeting]

1. A status report of the Task Force's development of options for organizing Managed Health Care Regulatory Oversight [Executive Director Phil Romero, Ph.D.].

Chairman Enthoven started the session by introducing Task Force Executive Director Dr. Phil Romero who would be talking about Managed Health Care Oversight. Executive Director Romero then distributed two packets to Task Force members, entitled "Background and Organization of State Regulation of Managed Care" and "Managed Care Improvement Task Force Questionnaire."

Executive Director Romero stated that one of the issues that catalyzed the creation of the Task Force was the question of which state organization should have responsibility for regulating managed care organizations. He felt that the issue of who should regulate [i.e., which organization should have oversight] was interdependent with the issues of what the scope of regulation should be and what the policy philosophy governing those regulations should be.

Executive Director Romero then presented a summary of the Delphi questionnaire administered to Task Force members in June 1997. Based on Task Force members' responses, seven out of eight members do not believe that the current regulatory structure is working optimally. Five out of six members think that HMO's should be regulated by the same agency as other managed care insurance entities. Five out of six members agree that the same regulatory authority should exercise oversight authority over the delivery system [i.e., medical groups] as well as health plans. A majority of Task Force members favored a new regulatory organization, while a minority was dispersed among several existing organizations. Executive Director Romero summarized that the Task Force members seemed to favor both horizontal regulatory consolidation across types of insurance entities and vertical integration among the health care delivery system.

Executive Director Romero then presented a matrix summarizing current state regulatory authority. He pointed out that there is duplication in the system, which leads to at least two unfortunate consequences. First, when multiple organizations are responsible for regulating the same entity, consumers do not know who to call and who makes decisions. Second, the duplication either [depending on one's point of view] places a burden on regulatees by creating an uneven playing field and duplicative rules or allows regulatees to choose their regulator [presumably a less stringent one] based on a business strategy.

Executive Director Romero then offered several goals to consider when designing a consolidated regulatory system. First, like substitutes should be regulated by the same entity. Executive Director Romero suggested starting with single oversight authority over prepaid health plans and then consider adding in, in priority order, authority over indemnity insurance, medical groups, individual clinicians, and facilities. Second, in terms of efficiency, the regulator should foster market evolution wherever possible, as long as that evolution is consistent with public policy goals. Third, in terms of fairness and rigor, similar organizations should be subject to similar rules and measured against similar yardsticks by a single regulator. Fourth, the transition costs of consolidating should be kept fairly low or should be compensated with savings. Executive Director Romero then invited comments from the Task Force.

Dr. Alpert suggested separating the regulation of managed care, allowing the Department of Corporations [DOC] to continue to regulate the corporate aspects and moving the regulation of quality to a consumer-centered entity.

Ms. Decker questioned whether a consolidated regulatory structure might have undue influence over regulatees. She was concerned that the regulator have clear lines of authority with appropriate expertise to address the different areas of regulation.

Executive Director Romero raised the question of how the regulator should be organized [e.g., should it have a single, appointed head or should it be a board structure].

Mr. Zatkin brought up three points. First, he stated that while there may be overlapping regulation in terms of quality, the individual functions [e.g., licensure of individuals versus facilities versus plans] are very different and would still need to be maintained even if they were located in the same agency. Second, he stated that Medi-Cal has a fiduciary obligation as purchaser that is different from the Department of

Corporations. Executive Director Romero clarified that he would separate purchasing organizations from regulatory organizations. Third, Mr. Zatkin stated that indemnity insurance is fundamentally different from HMOs and advocated that the Task Force focus on managed care.

Mr. Williams stated that before streamlining, each regulatory entity's mission and focus should be examined. That exercise would suggest areas for process improvements without losing the original mission.

Dr. Karpf suggested that the Task Force first identify the important problems that exist, examine how those problems are or are not being addressed, and then consider recommendations about the regulatory structure.

Ms. Severoni noted that accountability to consumers and to providers should be among the core principles for the regulatory system. She also suggested the Task Force that encourages consumer-driven innovation.

Dr. Spurlock asserted that changing the regulatory structure will not restore the public's trust. Dr. Alpert stated that if the regulatory structure were consumer-centered and focused on quality of health care delivery, it might restore public trust.

Mr. Zaremberg questioned why people want to change the regulatory structure. Is it to change the regulatory structure? Is it to restore public trust? Is it because the current regulators have inadequate resources or are not following the law?

Chairman Enthoven asked if a person with an extensive background in health care should head the regulatory agency. He also suggested that the Task Force have a sense of which laws should be enforced with higher priority. Finally, he discussed the need for better coordination among regulators of the various health care system components.

Mr. Hiepler stated that the focus of the Task Force starts with consumer complaints and regulation surrounding the complaint process. He stated that from the consumer perspective, calling a regulatory "1-800" number should be the last resort because it is the least efficient way to solve problems. He suggested that the Task Force find incentives to get the consumer involved in resolving their own disputes.

Mr. Kerr agreed with Dr. Alpert's distinction between the business side and the quality side of managed care, but he thought there should be one organization dealing with quality of care. Because quality is so important to the public, one organization should oversee "everything that the patient sees." He also raised the issue of establishing minimum standards of performance, in terms of outcomes, to offer health care in the state of California.

Break

B. Status Report on the Task Force Public Survey 12:00 P.M.

Ms. Helen Schauffler, Ph.D., principal investigator for the Task Force public survey, stated that the goal of the survey was to conduct a scientifically valid survey of insured Californians to document the prevalence of problems consumers are experiencing with their health insurance plans and to gain a better understanding of the types of problems, their severity, and the ability of consumers to resolve them successfully.

The survey was composed of three randomly drawn samples. The first sample contained 1200 insured Californians over 18 years of age who had lived in California for at least one year. The second was a specific sample of people who indicated they are either dissatisfied or very dissatisfied with their current health insurance plan and/or people who indicated that they have had a specific problem with their health plan or health insurance in the past 12 months. The third sample was composed of approximately 500 insured Californians who are frequent users of the health care system and have a high level of contact with the health care system in the last year.

Dr. Schauffler described the survey instrument development process. Eleven members of the Task Force and thirteen national experts participated. The final survey was 25 minutes in length and was sent to the Field Research Corporation for pre-testing.

The purpose was to compare consumers' experiences across health insurance plan types, gathering information about plan characteristics, choices of health plan physicians, specialist care, hospital care, specific problems consumers have had with the health insurance [type and severity], grievance process, extent to which the problem was resolved, satisfaction with their plan, opinions on policy issues, health status, demographics, etc.

V. PUBLIC COMMENT - 12:20 P.M.

Chairman Enthoven then proceeded to public comment. Two persons indicated their wish to speak .

1] Ms. Lynnie Morgan described her experiences related to her daughter's health care. She suggested that Task Force members reinstate the integrity of the doctor-patient relationship by encouraging stronger regulations from the Department of Corporations. She expressed regret that there were no "pure consumers" on the Task Force. She asked that the Task Force vote in favor of policies that are in the best interest of the consumer/patient.

2] Ms. Gerda Miller thanked the Task Force members for standing up to the Governor and telling him that he should not use the Task Force as a reason to veto enrolled managed health care legislation. She also voiced her wish that the Task Force conduct additional public hearings and publicize them better, so as to encourage ordinary people to participate in the decision making process.

Lunch Break

VI. EXPERT RESOURCE GROUP REPORTS AND DISCUSSION - 12:45 P.M.

A. Expanding Consumer Choice [Task Force members: John Ramey and Allan Zaremberg]

In his introduction, Chairman Enthoven said that in the early days in the HMO movement, one of the cardinal principles was individual choice. Doctors did not want to be required to take care of patients who really did not want to be there, because that would undermine the doctor-patient relationship. He discussed the importance of the HMO Act of 1973 in opening up the market to competition among health plans. He said that the state is highly constrained from regulating in this area due to the Employee Retirement and Income Security Act [ERISA].

Mr. Zaremberg started his presentation by saying that the economics of choice are different in the health care arena because one entity pays and another consumes.

Mr. Zaremberg stated that one way to increase choice would be to increase the number of people in purchasing pools and for each purchasing pool to have a superdirectory of physicians. He said that small, medium, and large size employers should be able to offer their employees a menu of health plans. Consumers should be able to look at the directory and decide which physician they want for their primary care provider. Mr. Zaremberg felt that employers who offer employee benefits might pay for one hundred percent of an HMO plan and then have employees decide if they want to pay for the additional cost of a plan that allows access to physicians outside the network. This scenario would bring into play the traditional economics of elasticity for the consumer.

Mr. Zaremberg questioned how to go about increasing the number of people in purchasing pools. He stated that nobody had applied to create their own purchasing pool under recent legislation, SB 1559. He felt this might be related to the legislation's restrictions on the role of agents and brokers. He suggested finding a way to bring the agents' and brokers' incentives in the development of more purchasing pools without compromising the pools' integrity. He also stated that a recommendation regarding streamlining the purchasing pool process would be forthcoming.

Mr. Ramey stated that one of the reasons the Task Force is able to discuss choice is that there have been relatively stable premiums in California lately. He cautioned against making recommendations that would undermine that stability and cause a focus on price rather than quality.

Mr. Ramey pointed out that risk selection is a primary factor when thinking about creating more choice in the marketplace. He questioned whether, as more purchasing pools entered the market, they might begin to distinguish themselves by their ability to attract the best risks.

Mr. Zaremberg mentioned the possibility of subsidies for the creation of purchasing pools or for employers who use purchasing pools. He cautioned all Task Force members to ask themselves, when considering subsidies, where the taxpayer's money would be best spent in health care.

In response to a question from Executive Director Romero, Mr. Ramey stated that he would not be comfortable with any recommendation that added cost to the system because many people are not able to afford health coverage now.

Mr. Zatkin asked for Mr. Ramey's opinion as to why the Health Insurance Plan of California [HIPC, a purchasing pool for employers with 2 to 50 employees] hadn't attracted more employers and what he thought of proposals to expand its eligibility. Mr. Ramey responded that the growth of the HIPC has been phenomenal given that it is a new product in a completely voluntary system and that it has no marketing funds. He also felt that the HIPC's eligibility could not be expanded without also creating underwriting reforms, guaranteed issue, rate bands, etc. Mr. Zaremberg questioned whether such reforms might leave employers with fewer choices, especially in terms of the availability of PPO products.

Mr. Zaremberg noted that with increased choice and competition, health plans have to divert more money from treatment to marketing. Mr. Kerr commented that there is a difference between information and marketing. Ms. Severoni stated that in one Medi-Cal program plans were not allowed to advertise – all information had to come through the program. Dr. Conom noted that Knox-Keene has very specific disclosure laws and that those laws are essentially not being enforced. She suggested the Task Force recommend enforcement of those laws.

Chairman Enthoven mentioned that ERISA [Employee Retirement Income Security Act] preempts state regulation of employee benefits, meaning states may not mandate benefit choices on employers.

Dr. Karpf stated that discussion of informed choice leads to the issue of standardized coverage. Chairman Enthoven agreed, stating that when the University of California adopted a standardized coverage contract people were more willing to switch plans and shop for price. Ms. Bowne cautioned against expanding choice solely through purchasing pools and against having only one plan design. She stated that such an approach leads to homogenized commodities and suggested creating a structure that leaves room for indemnity plans for those people who want to choose and pay for them. Dr. Karpf clarified that he was advocating a basic plan with opportunities to buy upgrades. Mr. Ramey stated that it is impossible to have informed choice of plan without some standard for comparison.

Mr. Bishop stated that the Knox-Keene Act imposes both disclosure and marketing requirements and that those laws are being enforced.

B. Provider Incentives [Task Force members: Dr. Donna Conom and Steve Zatkin] 2:30 P.M.

Dr. Conom commented that there has been a pendulum-type swing from fee-for-service indemnity insurance to capitation via managed care. The pendulum needs to swing back somewhere in between since both extremes have drawbacks.

Dr. Conom then described the basic types of physician compensation, including fee-for-service, salary, and capitation. She also described some incentive methods, including withholds and bonuses. She listed reasons that physicians complain about capitation, including reasons such as it creates financial conflict of interest, encourages cherry picking, and discourages improved care of chronic and serious diseases.

Dr. Conom described how the intensity of incentives varies, stating that if incentives are too intense they result in inferior care even if it is assumed that physicians desire to give good care. She said that the intensity decreases as the incentive is spread over more procedures, physicians and patients; involves a smaller percentage of the individual physician's practice; or is calculated over a longer period of time. She noted that physicians are also motivated by non-financial incentives.

Dr. Conom stated that the ideal patient-physician relationship includes choice, competence, communication, compassion, continuity, no conflict of interest, and confidentiality. She described a successful incentive strategy as one that is perceived as fair by individual physicians, is easy to understand, has a quick impact, and has a positive structure focusing on carrots rather than sticks.

Mr. Zatkin described how physician incentives are currently addressed in law, both at the federal and state levels. At the federal level, health plans that participate in Medicare or Medicaid on a prepaid basis are prohibited from using incentives to limit services to an individual enrollee. In addition, plans must meet certain requirements if they place physicians at "substantial financial risk", meaning more than 25% of the potential payment is at risk. In that case, the plan must provide stop-loss protection and survey its members for satisfaction. At the state level, the Department of Corporations requires medical decisions to be free of administrative and financial involvement. AB 2649, enacted in 1996, prohibits incentives to reduce services to individuals or groups of enrollees. It also requires health plans to disclose their basic method of reimbursement and whether
financial incentives are used.

Mr. Zatkin identified three issues for the Task Force to address: are there additional incentive arrangements that should be prohibited; should there be additional disclosure; and are there incentive arrangements that encourage best practices that the Task Force might recommend.

Dr. Karpf noted that fee-for-service might encourage physicians to provide more care than is appropriate and capitation might encourage physicians to provide less care than is appropriate, but the concern is that no one knows what the appropriate level really is. He suggested developing a body that can define what is "appropriate".

Mr. Hiepler argued for more explicit disclosure of how physicians are paid because "an informed patient is going to be the best served patient." He stated that disputes are best handled at the doctor-patient level, but if a patient doesn't know or understand the physician's incentives, resolution is harder. Task Force members discussed the details of how such disclosure might be made. Dr. Spurlock argued that disclosure of the specific dollar amounts would be an infringement on the physician's or medical group's ability to negotiate rates. Mr. Shapiro suggested that rather than relying too heavily on disclosure the Task Force should examine systemic approaches to removing incentives that are too intense. Mr. Bishop questioned how empowering or meaningful such disclosure would really be to consumers and whether incentives other than capitation should be disclosed. He felt that quality of care should be the focus.

C. Dispute Resolution Process [Task Force members Ms. Barbara Decker and Mr. Peter Lee] - 4:15 P.M.

Ms. Barbara Decker suggested maintaining some level of consistency in the dispute resolution process, because consumers do not know how to navigate the system when there is so much variation between plans and plan types. She stated that her staff spend a lot of time helping employees deal with their health care problems because they can't figure out how to resolve their complaints. She described differences in terminology and timing that lead to confusion. She also discussed differences in the ultimate recourse available to consumers in different types of plans, including binding arbitration, external review, administrative law judge hearings, federal courts, etc.

Several Task Force members expressed support for consistent standards. Mr. Kerr stated that there must also be penalties for those who fail to meet the standards. Regarding the issue of whether DOI-regulated plans should be subject to those same standards, Mr. Zatkin stated that if there is no discernible rationale that relates to the nature of the organization, consistency should be the goal. Mr. Lee pointed out that ERISA plans are subject to very different standards. Chairman Enthoven suggested the Task Force could recommend that the legislature petition the US Congress to change ERISA. Mr. Kerr further suggested making the recommendation to the Presidential Commission. Ms. Bowne cautioned that if there are too many changes to ERISA employers may decide not to offer coverage.

Mr. Lee mentioned that in future meetings, he would like to discuss external sources of assistance for patients who are having problems with their health plan and the possibility of third party review of medical assessment issues.

PUBLIC COMMENT - 4:45 P.M.

1) **Mr. Warren Leach** commented on the Diabetic Supply Bill [SB 1220 introduced in 1997]. He said that the cost of diabetic testing strips continues to rise. Mr. Warren also added that an ounce of prevention is worth a pound of cure so he suggested that provision of these devices should be mandated by law.

V. ADJOURNMENT - 5:00 P.M.

Chairman Enthoven said that without objection, the study session would be adjourned. Hearing and seeing no objection, Chairman Enthoven declared that the August 28th, Study Session was adjourned.